MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Highpoint Pharmacy P.O. Box 172615 Arlington, TX 76003	MDR Tracking No.: M4-03-6593-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address State Office of Risk Management Box 45	Date of Injury: Employer's Name: Insurance Carrier's No.: WC1862325

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/10/03	01/10/03	HCPCS Code A4570	$40.35	$40.35

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 06/05/03 states in part, "…The expected out come of this issue is that we feel the claims should be paid. In accordance with DME Ground rule Section IX c states invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier or if no pre-negotiated amount, the fair and reasonable rate. We have billed the Carrier our usual and customary rate and have provided the Carrier with examples of audit sheets and/or copies of checks where other carriers in this area have established the $73.70 charge for the cock-up wrist and forearm splint as a fair and reasonable amount as the Commission has not established a MAR for this procedure.

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 06/30/03 states in part, "…The requestor's only evidence of reimbursement is the submission of Explanation of Benefits (EOB) and checks from other insurance carriers. In light of recent SOAH decisions where providers submitted other carrier's EOB's as evidence of payment. SOAH has placed minimal value on such EOB's for establishing fair and reasonable fees…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- HCPCS Code A4570 (cock-up wrist and forearm splint) for date of service 01/10/03. The carrier paid $33.44 and used payment exception code "M – Reduced to fair and reasonable". Per Rule 133.1(a)(8) the requestor submitted convincing evidence to support the amount billed was fair and reasonable and meets the standards set out in Rule 413.011 of the Texas Labor Code. Additional reimbursement in the amount of $40.35 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
1/10/2003	A4570	$40.35	$40.35				
				Total Left Column:			$40.35
				Total Amount Due:			$40.35

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $40.35. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	01/13/05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____